THE PRESIDENT'S PLAN TO MODERNIZE AND STRENGTHEN

MEDICARE

FOR THE 21st CENTURY

DETAILED DESCRIPTION

NATIONAL ECONOMIC COUNCIL
DOMESTIC POLICY COUNCIL

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PRESIDENT'S PLAN FOR STRENGTHENING AND MODERNIZING MEDICARE FOR THE 21st CENTURY

TABLE OF CONTENTS

OVERVIEW:
PRESIDENT'S PLAN TO STRENGTHEN AND MODERNIZE MEDICARE FOR THE 21st CENTURY

On June 29, 1999, President Clinton unveiled his plan to modernize and strengthen the Medicare program to prepare it for the health, demographic, and financing challenges it faces in the 21st century. This historic initiative would: (1) make Medicare more competitive and efficient; (2) modernize and reform Medicare's benefits, including the provision of a long-overdue prescription drug benefit and cost sharing protections for preventive benefits; and (3) make an unprecedented long-term financing commitment to the program that would extend the estimated life of the Medicare Trust Fund until at least 2027. The President called on the Congress to work with him to reach a bipartisan consensus on needed reforms this year.

MAKING MEDICARE MORE COMPETITIVE AND EFFICIENT. Since taking office, President Clinton has worked to pass and implement Medicare reforms that, coupled with the strong economy and the Administration's aggressive anti-fraud and abuse enforcement efforts, have saved hundreds of billions of dollars and helped to extend the life of the Medicare Trust Fund from 1999 to 2015. Building on this success, his plan:

- **Gives traditional Medicare new private sector purchasing and quality improvement tools.** The President's proposal would make the traditional fee-for-service program more competitive through the use of market-oriented purchasing and quality improvement tools to improve care and constrain costs. It would provide new or broader authority for competitive pricing within the existing Medicare program, incentives for beneficiaries to use physicians who provide high quality care at reasonable costs, coordinating care for beneficiaries with chronic illnesses, and other best-practice private sector purchasing mechanisms. Savings: $25 billion over the next 10 years.

- **Extends competition to Medicare managed care plans by establishing a "Competitive Defined Benefit" while maintaining a viable traditional program.** The Competitive Defined Benefit (CDB) proposal would, for the first time, inject true price competition among managed care plans into Medicare. Plans would be paid for covering Medicare's defined benefits, including the new drug benefit, and would compete over cost and quality. Price competition would make it easier for beneficiaries to make informed choices about their plan options and would, over time, save money for both beneficiaries and the program. The CDB would do so by reducing beneficiaries' premium by 75 cents of every dollar of savings that result from choosing plans that cost less than traditional Medicare. Beneficiaries opting to stay in the traditional fee-for-service program would be able to do so without an increase in premiums. Savings: $8 billion over the next 10 years, starting in 2003.

- **Constrains out-year program growth, but more moderately than the Balanced Budget Act (BBA) of 1997.** To ensure that program growth does not significantly increase after most of the Medicare provisions of the BBA expire in 2003, the proposal includes out-year policies that protect against a return to excessive growth rates, but are more modest than those included in the BBA. These proposals along with the modernization of traditional Medicare would reduce average annual Medicare spending growth from an estimated 4.9 percent to 4.3 percent per beneficiary between 2002 and 2009. Savings: $39 billion over next 10 years (including interactions and premium offsets).

- **Takes administrative and legislative action to smooth out the BBA provider payment reductions.** The proposal includes a 7.5 billion "quality assurance fund" to smooth out provisions in the BBA that may be affecting Medicare beneficiaries' access to quality services. The Administration will work with Congress, outside groups, and experts to identify real access problems and the appropriate policy solutions. The plan also includes a number of administrative actions to moderate the impact of the BBA on some health care providers' ability to deliver quality services to beneficiaries. Finally, it contains a legislative proposal to better target disproportionate share hospitals. Cost: $7.5 billion over 10 years.

MODERNIZING MEDICARE'S BENEFITS. The current Medicare benefit package does not include all the services needed to treat health problems facing the elderly and people with disabilities. The President's plan would take strong new steps to ensure that Medicare beneficiaries have access to affordable prescription drugs and preventive services that have become essential elements of high-quality medicine. It also would address excess utilization and waste associated with first-dollar coverage of clinical lab services and would reform the current Medigap market. Finally, it integrates the FY 2000 President's Budget Medicare Buy-In proposal to provide an affordable coverage option for vulnerable Americans between the ages of 55 and 65. Specifically, his plan:

- **Establishes a new voluntary Medicare "Part D" prescription drug benefit that is affordable and available to all beneficiaries.** The historic outpatient prescription drug benefit would:

    - Have no deductible and pay for half of the beneficiary's drug costs from the first prescription filled each year up to $5,000 in spending ($2,500 in Medicare payments) when fully phased-in by 2008.

    - Ensure beneficiaries a price discount similar to that offered by many employer-sponsored plans for each prescription purchased – even after the $5,000 limit is reached.

    - Cost about $24 per month beginning in 2002 (when the coverage is capped at $2,000 in spending) and $44 per month when fully phased-in by 2008. (This is one-half to one-third of the typical cost of private Medigap premiums.)

    - Ensure that beneficiaries with incomes below 135 percent of poverty ($11,000/$15,000 single/ couples) would not pay premiums or cost sharing for Medicare drug coverage. Those with incomes between 135 and 150 percent of poverty would receive premium assistance as well. The Federal government would assume all of the costs of this benefit for those above poverty.

    - Provide financial incentives for employers to develop and retain their retiree health coverage if it provides a prescription drug benefit to retirees that was at least equivalent to the new Medicare outpatient drug benefit. This approach would save money for the program because the subsidy given would be generous enough for employers to maintain coverage yet lower than the Medicare subsidies for traditional participants.

    Most Medicare beneficiaries will probably choose this new prescription drug option because of its attractiveness and affordability. Because older and disabled Americans rely so heavily on medications, we estimate that about 31 million beneficiaries would benefit from this coverage each year. Cost: $118 billion over the next 10 years, beginning in 2002.

- **Eliminates all cost sharing for all preventive benefits in Medicare and institutes a major health promotion education campaign.** This proposal would cost $3 billion over 10 years and would:

    - Eliminate existing copayments and the deductible for preventive service covered by Medicare, including colorectal cancer screening, bone mass measurements, pelvic exams, prostate cancer screening, diabetes self management benefits, and mammographies.

    - Initiate a three-year demonstration project to provide smoking cessation services to Medicare beneficiaries.

    - Launch a new, nationwide health promotion education campaign targeted to all Americans over the age of 50.

- **Rationalizes cost sharing.** To help pay for the new prescription drug and preventive benefits, the President's plan would save $11 billion over 10 years by rationalizing the current cost sharing requirements for Medicare by:

    - Adding a 20 percent copayment for clinical laboratory services. The modest lab copayment would help prevent overuse, and reduce fraud.

    - Indexing the Part B deductible for inflation. The Part B deductible index would guard against the program assuming a growing amount of Part B costs because, over time, inflation decreases the amount of the deductible in real terms. Compared to average annual Part B per capita costs, the deductible has fallen from 28 percent in 1967 to about 3 percent in 2000.

- **Reforms Medigap.** The President's plan would reform private insurance policies that supplement Medicare (Medigap) by: (1) working with the National Association of Insurance Commissioners to add a new lower-cost option with low copayments and to revise existing plans to conform with the President's proposals to strengthen Medicare; (2) directing the Secretary of HHS to determine the feasibility and advisability of reforms to improve supplemental cost sharing in Medicare, including a Medigap-like plan offered by the traditional Medicare program; (3) providing easier access to Medigap if a beneficiary is in an HMO that withdraws from Medicare; and (4) expanding the initial six month open enrollment period in Medigap to include individuals with disabilities and end stage renal disease (ESRD).

- **Includes the President's Medicare Buy-In proposal.** The plan includes the President's proposal to offer American between the ages of 62-65 without access to employer-based insurance the choice to buy into the Medicare program for approximately $300 per month if they agree to pay a small additional monthly payment once they become eligible for traditional Medicare at age 65. Displaced workers between 55-62 who had involuntarily lost their jobs and insurance could buy in at a slightly higher premium (approximately $400). And retirees over age 55 who had been promised health care in their retirement years would be provided access to "COBRA" continuation coverage if their old firm reneged on their commitment. The $1.4 billion cost over 5 years is offset in the President's FY 2000 budget.

STRENGTHENING MEDICARE'S FINANCING FOR THE 21st CENTURY. The President's Medicare plan would strengthen the program and make it more competitive and efficient. However, no amount of policy-sound savings would be sufficient to address the fact that the elderly population will double from almost 40 million today to 80 million over the next three decades. Every respected expert in the nation recognizes that additional financing will be necessary to maintain basic services and quality for any length of time. Because of this and his strong belief that the baby boom generation should not pass along its inevitable Medicare financing crisis to its children, the President has proposed that a significant portion of the surplus be dedicated to strengthening the program. Specifically, his plan:

- **Extends the life of the Trust Fund until at least 2027.** Dedicating 15 percent of the surplus ($794 billion over 15 years) to Medicare not only contributes toward extending the estimated financial health of the Trust Fund through 2027, but it will also lessen the need for future excessive cuts and radical restructuring that would be inevitable in the absence of these resources.

- **Responsibly finances the new prescription drug benefit through savings and a modest amount from the surplus.** The new drug benefit would cost about $118 billion over 10 years. Its budgetary impact would be fully offset by:

    - Savings from competition and efficiency. About 60 percent of the $118 billion Federal cost of the new Medicare prescription drug benefit would be offset through these savings.

    - Dedicating a small fraction of the surplus. About $45.5 billion of the surplus allocated to Medicare would be used to help finance the benefit. To put this amount in context, it is:

        - Less than one eighth of the amount of the surplus dedicated for Medicare (2 percent of the entire surplus); and

        - Less than the reduction in the Medicare baseline spending between January and June, 1999.

    Policy experts advising the Congress (MedPAC, CBO, and the Medicare Trustees) have consistently stated their belief that much of the recent decline in Medicare spending beyond initial projections is due to our success creating a strong economy and in combating fraud and waste. Reinvesting the savings that can be reasonably attributed to our anti-fraud and waste activities into a new prescription drug benefit is completely consistent with the past actions of the Congress and the Administration utilizing such savings for programmatic improvements.

PRESIDENT'S PLAN TO STRENGTHEN AND MODERNIZE MEDICARE FOR THE 21st CENTURY

- **Goals for Reform**:
  - ° Make Medicare More Competitive and Efficient
  - ° Modernize Medicare's Benefits
  - ° Strengthen Medicare's Financing for the 21st Century
- **Reduces Medicare spending for current services by $72 billion over 10 years.** About half of these savings come from innovative proposals to adopt successful private sector tools and competition. As a result of these policies, Medicare growth per beneficiary from 2003 to 2009 would slow from 4.9 percent to 4.3 percent.
- **Adds an optional prescription drug benefit.** This benefit would cost $118 billion over 10 years. This cost is only about 5 percent of total Medicare spending in 2009 (net of premiums).
  - ° Over 60 percent of the costs are offset by the proposal's savings.
  - ° The remaining $45.5 billion would come from the Medicare allocation of the surplus. This amount is one-eighth of the $374 billion over 10 years dedicated to Medicare, and less than 2 percent of the overall surplus.
- **Extends the life of the Medicare Trust Fund to at least 2027**. The President's plan would dedicate 15 percent of the surplus to strengthen Medicare. This amount, when combined with the offset for the drug benefit and Part A savings, would extend the estimated life of the Medicare Trust Fund for a quarter century from now, through at least 2027.

PRESIDENT'S PROPOSAL
(Dollars in Billions, Trustees' Baseline)

	00-04	00-09
COMPETITION & EFFICIENCY		
Medicare Modernization	-5	-25
Competition	-0	-8
Provider Savings	-4	-39*
Provider Set-Aside	+4	+7.5
Total	***-5***	***-64.5***
MODERNIZING BENEFITS		
Prescription Drug Benefit	+29	+118
Cost Sharing Changes	-2	-8
Total	***+27***	***+110***
DEDICATING FINANCING		
Contribution to Solvency	-28	-328.5**
Surplus for Drug Benefit	***-22***	***-45.5***
Surplus Allocation	*-50*	*-374*

*Includes $5.7 billion in interactions/premium offset
** Does not count toward package

PRESIDENT'S PLAN TO STRENGTHEN AND MODERNIZE MEDICARE FOR THE 21st CENTURY

I. MAKING MEDICARE MORE COMPETITIVE AND EFFICIENT

1. Private Sector Purchasing & Quality Improvement Tools for Traditional Medicare

Overview. This proposal would build on the President's commitment to modernize Medicare by allowing it to adopt best practices from the private sector to improve quality and constrain cost growth. In the past decade, private purchasers of health care have developed effective techniques that target both beneficiaries with special health care needs (recognizing that they account for a large share of costs and could benefit from care management) and high-quality, efficient providers (to provide an incentive to improve care and reduce costs). Such practices include: reducing beneficiary cost sharing in return for using high quality/cost-effective providers; improving and coordinating care for beneficiaries through management of specific diseases and/or all of beneficiaries' care; and purchasing through competition, selective contracting, and negotiated payment rates.

Currently, Medicare has little statutory authority to implement these types of strategies, notably to reward providers of high-quality, cost-effective care. The National Academy for Social Insurance has called for Health Care Financing Administration (HCFA) to be given greater flexibility to use these types of private sector tools in Medicare. In addition, HCFA, through demonstrations, has been exploring for several years more flexible arrangements for paying providers and health plans to encourage high-quality care. This proposal would build on this work and would authorize a broader use of these best practices from the private sector where applicable and feasible. This authority would include safeguards for beneficiaries (e.g., programs would be voluntary; have quality assurance measures) and providers, to assure a process that new processes are accountable, transparent, clear and certain. The management reforms included in this proposal, including having an outside panel of private sector management experts advise HCFA, are also integral to this initiative's success (note: the reforms outlined below would not apply to the prescription drug benefit which has built-in a flexible management authority since it is new).

a. Promoting use of high-quality, cost-effective health care providers

Policy: This proposal would allow Medicare to adopt the private-sector practice of giving high-quality, cost-effective providers special designations, and giving beneficiaries incentives to use these providers while maintaining beneficiary freedom of choice. It would do so through two proposals.

The first part of this proposal is to create a new Medicare Preferred Provider Option (PPO), allowing Medicare to use one of the most common private-sector purchasing tools. PPOs are the

predominant type of managed care plan for people under the age of 65. Unlike HMOs which typically restrict access to providers not in their network, insurers that sponsor PPOs typically pay all providers for care for their enrollees. However, beneficiaries pay less when providers in the PPO's network are used. In the Medicare option, beneficiaries would pay lower cost sharing when using preferred providers. The quality standards of the Medicare PPO would assure that beneficiaries would be treated by high-quality health care providers.

Rather than developing her own networks, the Secretary would contract with existing organizations with PPOs that demonstrate their ability to meet quality and utilization management standards. To become a Medicare preferred provider, practitioners' and providers' claims history and quality information would be assessed. Only those applicants with a demonstrated history of cost-effective medical practice patterns would be selected as preferred providers. PPO arrangements would be in areas where they are common in the private sector already, so provider familiarity will make it easier to implement. PPO participants would be given administrative advantages, such as faster claims payment and alternative administrative and related procedures.

Beneficiaries would gain by choosing preferred providers, since they would pay less in cost sharing and have a strong assurance about the quality of the provider. Beneficiaries could have less need to buy private supplemental Medigap insurance to reduce cost sharing, since cost sharing could be somewhat reduced by using Medicare preferred providers. Those with continued interest in Medigap could purchase a new special policy (discussed in section II-3-c) that complements the PPO, which should be less expensive than the typical Medigap policy.

The second proposal would expand the current "Centers of Excellence" demonstration to make it a permanent part of Medicare. The purpose of the Centers of Excellence designation is to: (1) recognize and reward providers who deliver complex medical care with exceptional quality and (2) provide incentives for beneficiaries to use these providers. Competitively-selected facilities would be paid a single rate for some or all services related to a surgical procedure or medical condition. Beginning in 2001, the Secretary would establish Centers of Excellence throughout the nation for coronary artery bypass grafts (CABG) and other heart procedures, knee replacement surgery, and hip replacement surgery. The Secretary would also specify other appropriate procedures and conditions for which it is appropriate to designate selected exceptional providers as Centers of Excellence.

As in the demonstration, selected facilities would have to meet special quality standards and would be required to implement a quality improvement plan. Facilities would retain the Center of Excellence designation for a three-year period so long as they continue to meet these quality standards. The single rate paid to a Center for a particular procedure or admission could not exceed the aggregate amount that would otherwise be made for beneficiaries in order to produce overall savings to the Medicare program. In addition, experience with the demonstration suggests that the designation as a Center gives the facility a bargaining tool to use with their private purchasers. Beneficiaries would not be required to receive services at Centers, but Centers would be allowed to provide incentives such as reducing or waiving cost sharing, offering private rooms, or paying for travel and lodging expenses to attract beneficiaries.

Background/rationale: In the private sector, PPOs and point-of-service (POS) plans have become the predominant form of managed care. For example, most Federal workers and their families are enrolled in the Blue Cross/Blue Shield Preferred Provider Organization in the Federal Employees Health Benefits System (FEHBP). These arrangements enable plans to work more effectively with participating providers to achieve quality and cost goals. Enrollees of these kinds of plans face lower cost sharing and may have other advantages in using participating physicians or other providers. By selecting providers for special designation and providing beneficiaries incentives to use these providers, Medicare would be able to purchase high-quality services and items at more competitive rates, as private plans are able to do now. Providers would compete to be selected based on their performance and price and they would actively seek out the designation as a preferred Medicare provider.

The Centers of Excellence proposal stems both from private sector practices and a recent Medicare demonstration project. From 1991-1998, HCFA conducted a demonstration through which high-quality facilities were paid a single fee to provide all of the facility, diagnostic and physician services associated with coronary artery bypass graft (CABG) surgery. The Centers of Excellence were selected on the basis of their outstanding experience, outcomes, and efficiency in performing these procedures. Medicare achieved an average of 12 percent savings for CABG procedures performed through the demonstration while most facilities experienced increased market share. Studies have shown that average costs and length of stay for by-pass surgery, for example, fall with increases in patient volume while quality improves. Most experts agree that Centers of Excellence is a proven success that could improve quality and reduce costs if used nationwide by Medicare.

b. Primary care case management and disease management

Policy: This proposal would give Medicare the flexibility to structure payments and systems of care focused on the specific health needs of beneficiaries, which should both improve quality of care and reduce costs. The two major tools Medicare would adopt are primary care case management and disease management.

Primary care case management (PCCM) refers to a set of activities performed by primary care physicians to coordinate the full range of health care services used by participating beneficiaries. Medicare would be given the authority to develop PCCMs in areas or for beneficiary groups where there is evidence of lack of coordination of care or a pattern of inappropriate utilization, such as a high rate of hospitalization for conditions that could be treated in outpatient settings. Under this system, Medicare would selectively contract with high-quality physicians for PCCM services. Physicians would be paid in the usual way (fee-for-service) but would receive case management fees that could incorporate physician education and training. Primary care physicians would have an incentive to become a PCCM, since the designation would be exclusively for physicians who meet certain performance standards and other criteria. Further, the PCCMs would be marketed to encourage beneficiary enrollment, guaranteeing patient volume.

To encourage beneficiaries to voluntarily enroll with a primary care case manager, Medicare could offer additional benefits or lower cost sharing. The additional program costs from lower cost sharing or extra benefits would be offset by the reduction in costly services such as avoidable hospitalizations. Beneficiaries who meet the criteria for a PCCM would volunteer to remain with a PCCM for a period of time, and would receive all their health care either directly from, or through referral by, their primary care case manager.

Disease management authority would permit Medicare to take advantage of the recent development of special coordinated delivery systems for targeting certain high-cost health conditions. Private-sector organizations have developed models of care coordination for conditions like congestive heart failure and diabetes, by providing physician-directed, nurse-mediated disease management services. The Secretary would have the authority to competitively pay qualified entities who provide (or subcontract to provide) services including patient screening and assessment, review of medications, patient education, telephone consultations, physician interaction, home nursing visits, surveillance and reporting. To minimize fragmentation of care, Medicare could require single vendors to provide disease management for related conditions (e.g., congestive heart failure, hypertension, coronary artery disease, and diabetes). Medicare would set up the payment arrangements to achieve savings for the given diagnoses for participating beneficiaries. Beneficiaries would voluntarily choose to get their care from these providers, benefiting from the expertise and care coordination that is the hallmark of these disease management systems.

Background/rationale: Private health insurance plans are increasingly choosing to coordinate a range of health services, either for beneficiary needs or for a specific disease. Since a small fraction of beneficiaries (5 percent) account for 45 percent of Medicare spending, targeting their entire range of services or disease-specific services can improve quality as well as reduce costs. Primary care case managers (PCCMs) have been used by Medicaid and private health plans to improve access to quality care while reducing costs. For example, a study of Medicaid in Kentucky and Maryland found that PCCMs can reduce use of ancillary services and increase use of preventive services and primary care. This care management can be especially important for older and sicker beneficiaries, who may have diminished capacity to navigate the health care system.

Similar results have been emerging from disease management models. Private sector disease management vendors indicate they are achieving savings of 20 to 50 percent (before fees) for selected high-cost, chronic diseases, and have begun to guarantee improvement in patient satisfaction and clinical outcomes as well as cost savings.

c. Information and care coordination for Medicare-Medicaid dual eligibles

Policy: About six million Medicare beneficiaries also receive some benefits from Medicaid. These dual eligibles represent 17 percent of the Medicare beneficiary population (19 percent of the

Medicaid population), and account for 28 percent of total Medicare expenditures (35 percent of Medicaid expenditures). On average, dual eligibles are sicker, older and poorer (by definition) than other Medicare beneficiaries. In addition, the dual eligible population is more likely to suffer from cognitive impairment, mental disorders, and limitations in their ability to perform daily activities. The health frailties of dual eligibles often require comprehensive acute and long-term care services. However, these services are provided by two separate public insurance programs. This complex arrangement of services can be difficult to understand and navigate. In addition, providers for one program may be unaware of the actions of providers for another program, unintentionally duplicating or contradicting each other. This is exacerbated by the incentives to cost-shift between payers. This initiative assists these beneficiaries to better understand their benefits, tests models for coordinating and improving care, and evaluates whether Medicare and Medicaid savings can be achieved.

Information to all new Medicare-Medicaid beneficiaries on coverage. Under this proposal, all beneficiaries who become dually eligible (full Medicaid, Qualified Medicare Beneficiaries (QMBs) or Specified Low-Income Medicare Beneficiaries (SLMBs)) would be provided with an orientation package containing information on dual eligible benefits and the programs that serve them. The purpose of the orientation package would be to inform all dual eligibles about their special status, the Medicare and Medicaid programs, and how to obtain further information from HCFA, the states and other relevant offices. This package would educate beneficiaries on the benefits, rights and responsibilities that accompany dual eligible status. Specific information would include:

- Basic information on benefits available to each category of dual eligibles -- i.e., additional services beyond the Medicare benefit package, premium assistance and cost-sharing assistance.

- Where to get additional information about Medicare and Medicaid and the services available to dual eligibles, including key phone numbers: Medicare contacts; Medicaid Office; State Health Insurance Assistance Program; Office on Aging; and the Social Security Administration (SSA).

- Information on beneficiaries' rights under each program regarding grievances, appeals, and choice of provider (e.g., fee-for-service, managed care, etc.).

HCFA would work with states to design and distribute this orientation package nationwide. It would complement efforts underway by HCFA, states and local governments to expand enrollment through outreach campaigns.

Care coordination demonstration. This proposal would authorize a demonstration program to test care coordination models for Medicare beneficiaries who are also eligible for Medicaid and who remain in fee-for-service Medicare. Dual eligible beneficiaries who participate would receive a one-time, special clinical assessment, developed by geriatricians, of their acute and long-term care needs. Those with significant health care needs would qualify for a care coordination benefit

that would include primary care services and advice from a team of providers. This team would include a geriatrician, a social worker and a nurse who would provide general primary care services and would advise the beneficiary about Medicare and Medicaid care options. The team would suggest the best type of specialty acute care and make suggestions about when other long-term care and support are necessary such as personal care, nursing home care, or home health. Other models of care coordination could also be tested. Up to 25,000 beneficiaries would be eligible for this demonstration intended to test both whether outcomes are improved and whether savings can be achieved.

Provider groups would apply for the demonstration, and could include grass-roots organizations as well as larger health care organizations. HCFA would carefully screen provider applicants and monitor the demonstration to ensure that the providers were not using the demonstration as a way to maximize Medicare payments. The demonstration would require that providers have an agreement with their state for full cooperation.

Background/rationale: Confusion regarding Medicare and Medicaid benefits is common, and many low-income beneficiaries who are dually eligible are not aware of the benefits and programs that exist under Medicare and Medicaid to assist them. The orientation package would provide dual eligible beneficiaries with the information they need to better access the complex arrangement of health care services available to them and to take full advantage of the benefits they are entitled to as dual eligibles.

Having a provider or other professional assist beneficiaries in navigating the system is at least as important as clearly written, informative documents. Most examinations of options to coordinate care have focused on managed care models to improve care coordination for this vulnerable population. Yet, the majority of dually eligible beneficiaries choose to remain in fee-for-service. This new demonstration effort would test models for improving care coordination for beneficiaries who choose to remain in traditional fee-for-service Medicare.

d. Innovative purchasing tools and contracting reform

Policy: This proposal would give the Medicare the flexibility to promote high-quality, cost-effective care by using innovative purchasing techniques for current services (separate structure for prescription drug coverage). These techniques include: competitive pricing and selective contracting, negotiating payment rates in exchange for flexible administrative arrangements; negotiating bundled payments for related services; and testing and implementing incentive payments for group practices. It also would reform Medicare contracting.

Competitive pricing. This proposal would authorize use of competitive bidding and price negotiations to set payment rates for Part B items and services (except for physician services). Medicare would have the authority to select both the items and services, and the geographic areas, to be included in a bidding or negotiation process based on the availability of providers and the potential to achieve savings. Bids would be accepted only if providers met specified quality

and customer service standards. Protections would be built in for rural areas where this competition may be difficult. There would also be protections for bidders (e.g., median bid, not best price; no winner takes all). Medicare would also have the authority to selectively contract with providers who accept negotiated or bid prices and other contractual terms. Providers would have an incentive to participate to potentially secure a larger market share.

Improved negotiating authority would allow the current Medicare to negotiate alternative flexible administrative arrangements with providers and suppliers who: (1) agree to provide price discounts to Medicare, and (2) demonstrate better performance and higher quality. The administrative arrangements could include such incentives as simplifying claims processing, reducing billing payment cycle time, and alternative claims and cost settlement processing. The use of these special administrative arrangements could be targeted to areas where there is market competition and discount arrangements are common. In general, before an alternative arrangement would go into place, Medicare would assure that the arrangement would achieve program savings. These savings would result from discounts and selecting providers and suppliers who have demonstrated appropriate utilization practices.

Paying a single amount per case for all services at a site of care is another way of simplifying the traditional service-by-service payment structure and providing incentives for lower cost, high-quality care. This proposal would authorize Medicare to provide a single payment per case to combinations of practitioners, providers and suppliers for all care delivered at a specific facility or site of care (e.g., all physician and hospital services delivered in the hospital setting, or all professional and facility services delivered in a partial hospitalization program). For example, all payments for the surgeon, anesthesiologist, attending physician, and physician consultant(s) for each case would be combined with the applicable hospital DRG and paid to one entity. This combined amount would provide incentives for the physicians and hospital to work together to deliver higher quality, more efficient care. Those efficiencies would be shared with Medicare. This single payment arrangement would only be established if overall program savings are anticipated.

This proposal would also explicitly authorize a demonstration of bonus payments for physician group practices, which would be expanded nationwide if proven to be successful. Qualifying group practices would be offered bonus payments if they reduce excessive use and demonstrate positive medical outcomes for their patients. To qualify, a large physician group practice would be required to: meet or exceed certain size and scope criteria, submit acceptable clinical and administrative management plans, participate in acceptable quality improvement plans, submit required performance data, and distribute at least a portion of the bonus payments based on quality performance. Qualifying organizations would be given an annual per capita target based on the organization's own historic experience (e.g., average total Part A and Part B expenditures for the Medicare FFS beneficiaries seen by the practice in a base year). A bonus could be paid to the organization when actual total per capita expenditures in the performance year are lower than the target. A portion of Medicare savings -- separate from the bonus payment -- could be set aside each year and paid based on process and outcome improvements.

Contracting reform is a necessary first step in updating the tools HCFA needs to engage in

effective oversight of the Medicare contractors. This proposal, which is also in the President's budget, would allow HHS to use competition to select Medicare fiscal intermediaries and carriers. It would also allow Medicare to use entities other than insurance companies as its fiscal agents, and provide HHS greater flexibility in determining which functions should be performed under the contracts.

Background/rationale: Private and other public sector purchasers of health care have successfully used competition and negotiation to establish payment rates and assure high quality of health care services. Competitive pricing is now being tested through Medicare demonstrations and appears to be successful at constraining costs. For example, HCFA is currently conducting a demonstration of competitive bidding for durable medical equipment. For each product line, HCFA establishes a competitive range of bids and selects enough quality suppliers in that range to meet the necessary demand. Transition policies assure that current arrangements phase into the new system. The series of authorities in this package would allow for broader use of such arrangements that both assure a clear, fair process for providers as well as Federal savings and improved care for beneficiaries.

2. Competitive Defined Benefit Proposal

Overview. The proposal would create a new "competitive defined benefit" program that, for the first time, would inject price and quality competition among health plans in Medicare. Unlike the current Medicare+Choice system, plans would be reimbursed for their full price of offering the defined set of Medicare benefit including a new subsidized drug benefit, and would compete over cost and quality. Such price competition would make it easier for beneficiaries to make informed choices about their health plan options. It also would provide incentives for beneficiaries to choose private plans offering high-quality health care while also saving them money by reducing their Part B premium costs. This saves the government money as well. Importantly, beneficiaries opting to stay in the traditional fee-for-service program would be able to do so without an increase in premiums.

a. Beneficiary premiums based on choice of managed care plan

Policy: For the first time, the Medicare beneficiaries would have the ability to choose plans that can offer coverage with no or a lower premium than the traditional Part B premium. Right now, beneficiaries pay the same Part B premium regardless of the cost of their plan. Under the President's proposal, premiums would be lower if beneficiaries choose lower-cost managed care plans; the same if their plan's price is about equal to average traditional program costs; and more if their plan's price is higher than traditional Medicare costs. Beneficiaries opting to stay in traditional Medicare would pay their Part B premium as they do under current law; their premium would not be affected by this proposal. The system helps make beneficiaries more price sensitive, encouraging them to choose the highest quality, most efficient health plan option that suits their needs.

The amount that a beneficiary would pay in Part B premiums, assuming they opt for managed care, depends on the plan's price in relation to the traditional program costs (the Part D premium would also be included in this determination for participating beneficiaries). Those choosing a plan whose price is equal to 96 percent of traditional Medicare – the total payment that a plan will receive under current law in 2003 -- would pay the same, current-law Part B premium (Part D also for enrollees who choose it). Those choosing a plan that is more expensive than this amount would pay the full additional cost of the plan; those choosing a less expensive plan could keep 75 percent of the savings. At this rate and given the current costs of Medicare, a beneficiary choosing a plan whose price is at or below about 80 percent of the average traditional Medicare's cost would pay no Part B premium. Beneficiaries would select plans during an open enrollment period each year, based on comparative information on premiums and quality.

Background/rationale: Under today's system, private plans use extra benefits to attract beneficiaries. Plans can afford to do so in certain parts of the country because historically, they have been overpaid according to major studies by the General Accounting Office (GAO), Mathematica and the Medicare Payment Advisory Commission (MedPAC). Given the shortcomings in the Medicare benefit package, it is understandable why beneficiaries would opt for this coverage. However, it is often difficult for beneficiaries to judge the value of various benefit packages and determine which one is best for them. This both limits effective and fair competition and probably results in beneficiaries getting less value in extra benefits because some of the extra benefits may be of little or no use to some beneficiaries. It also encourages risk selection. Plans hoping to attract healthy beneficiaries typically offer coverage targeted to such beneficiaries – offering, for example, health club memberships, and coverage for care when travelling outside the U.S. For this reason, advocates of competitive approaches agree that benefits must be comparable in order to have true competition on price and quality. Another concern about the current system is that, because plan payments are higher in some parts of the country, beneficiaries in certain areas have the option of extra benefits through managed care – in many cases, a free prescription drug benefit -- while those in low-cost areas pay the same Part B premium and get few, if any, extra benefits if there are any plans available at all. The program subsidizes extra benefits in some parts of the country but not in others because of existing payment and program rules.

This proposal would allow managed care plans to compete for beneficiaries based on their price and quality in providing the defined set of Medicare benefits. This is possible because this proposal would also add the option of prescription drug coverage for all Medicare beneficiaries. Managed care plans would be explicitly subsidized for the prescription drug benefit. Moreover, the proposal puts money in the pockets of beneficiaries choosing low-cost plans, giving beneficiaries (rather than health plans) control over what extra benefits they are willing to buy and how they want to buy them. Plans would still have the option to offer extra benefits, but the premium for those benefits would not be subsidized by the government, reducing the inequities that occur today from area to area.

This competition could not work effectively without the new prescription drug option.

Beneficiaries have a great need for this coverage, and it is part of almost all standard private insurance plans today. Beneficiaries have sought out managed care plans with drug coverage in areas where they are available. It would be unfair to replace benefits competition with price competition without putting in place an option to ensure that all beneficiaries have access to subsidized drug coverage, not just those in managed care. Equally as important, Medicare would explicitly pay managed care plans for drug coverage, lessening the uncertainty about whether plans can afford to do so in the future.

b. Government payments based on plan prices

Policy: The government would pay Medicare managed care plans based on their prices, not a flat rate based on a statutory formula, as it does today. These Federal payments would be limited so that the government does not pay more than it does today (in general) but would be lower if beneficiaries choose lower-price plans. In other words, the government would save money when beneficiaries choose efficient plans – which does not happen in today's system. This should produce long-run efficiency and program savings if beneficiaries take advantage of the option to pay lower Part B premiums by enrolling in high-quality, cost-effective managed care plans.

Medicare payments to plans would be determined in two steps. First, private plans meeting Medicare eligibility criteria would bid on Medicare's defined set of benefits, including the new prescription drug and prevention benefits. Plans would have the option of including in this bid the cost of reducing or eliminating the cost sharing for Medicare benefits, so long as the value of that reduced cost sharing does not exceed 10 percent of the value of the defined Medicare benefits package. As is currently the case, the plans could further supplement the package by offering additional benefits for an additional supplemental premium, but these supplements would not count towards the price used to establish the government payment (note: the Secretary of Health and Human Services will examine the need and options for standardizing these supplemental benefits as part of her study on supplemental benefits in section II-3-d).

Second, this plan price would be compared to the cost of traditional Medicare for an average beneficiary. As under current law, maximum government payment for managed care plans would be set so that managed care enrollment of an average beneficiary would produce program savings. Specifically, the maximum government payment would be set so that the beneficiary pays the same Part B premium for a private plan with a price equal to 96 percent of traditional program costs. (Note: to the extent that savings from competition permit, this 4 percent current-law government savings from enrollment in a private plan could be reduced or eliminated). Instead of paying this flat amount for all plans, however, government payments would be based on the actual plan price when that price is below the maximum government payment level. As the plan price falls, the government payment also falls, by 25 percent of the reduction in price. Specifically, the government would pay the difference between the plan price and the beneficiary contribution (described above), up to a limit.

A different way to think about the government payment is as a percent of the total private plan

price. For plans whose price is below about 80 percent of the average traditional program costs, the government would pay 100 percent of the price, and beneficiaries would pay nothing to enroll in those health plans. For plans whose price is between 80 and 96 percent of traditional Medicare costs, the dollar amount of the government payment increases, but it declines as a percent of the price as the beneficiary premium increases. The government payment would be capped for plans whose prices are above 96 percent of traditional program costs. Stated simply, the government payment increases with plan price increases up to a limit. That limit is the amount that the government pays for an average beneficiary in the traditional program less a 4 percent discount to account for the greater efficiency of managed care. This 4 percent discount is the same as that captured under current program rules.

Government payments to medical savings account (MSA) plans and private fee-for-service plans, two new options included in the BBA, would remain the same as under current law for the first few years of the new system.

Background/rationale: Unlike Medicare which pays managed care plans a flat payment based on their fee-for-service costs irrespective of plan prices, many private employers and other health care purchasers base their payments on plans' actual prices, and pay a larger share of the cost of lower-cost plans, to encourage price competition. The President's proposal would adopt this private employers' approach. All managed care plans would be paid their full price through a combination of government and beneficiary payments. The split between how much the beneficiary pays and how much the government pays would depend on the plan price relative to traditional Medicare program costs. The higher the price, the more beneficiaries pay since the government contribution rate declines relative to the price of the plan. This approach, paying plans a percent of their price up to a limit, is similar to that of the Federal Employees' Health Benefits Program.

Because payments would be based on the actual plan price, not a flat rate structure, Medicare would save not only when beneficiaries switch from the traditional program to managed care (due to the 4 percent discount for plans that cost the same as traditional Medicare) but also when they move from higher to lower cost managed care plans. This will produce savings over time. If savings from competition are sufficient, the government discount from the switch to managed care could be phased out.

c. Risk and geographic adjustment

Policy: To ensure that competition is based on price and not risk selection, a strong risk adjustment system will need to be in place at the start of this proposal. Risk adjustment increases or decreases private plan payments based on the likelihood that a beneficiary will develop costly health problems. It lessens the incentive for private plans to search out healthy beneficiaries and avoid sick beneficiaries. The BBA directed HCFA to implement risk adjustment, which will be fully phased in by 2004. The government, not the beneficiary, makes the payment adjustment – so that all beneficiaries pay the same premium but the plan is fairly compensated. Because it is

essential to have risk adjustment in a competitive payment system, this proposal would begin in 2003 when the new risk adjustment system is almost fully implemented.

To maintain a level playing field between the traditional program and private plans, government payments to private plans under this proposal would include an adjustment for geographic cost differences that affect plan operations and costs. This would put the premiums for managed care and the traditional program on the same, national basis (rather than have the private plan premium be local and the fee-for-service premium be national). Specifically, the government would adjust payments for plans in high-cost areas to reflect the full local costs, which is more than under the BBA formula. The increases in government payments in low-cost areas included in the BBA would be maintained in the President's plan. In other words, the higher payments to rural managed care plans secured in the BBA would be maintained to encourage plan participation in underserved rural areas. This two-part geographic adjustment system would be studied in its first several years by the Secretary of Health and Human Services to assure that it produces the intended effect.

Background/rationale: One of the most important changes to managed care payments in the BBA was the required implementation of risk adjustment. Medicare covers many high-cost elderly and disabled beneficiaries who could benefit from coordination of care that managed care offers. The failure to adjust for these potential costs (beyond the current demographic factors such as age) creates incentives for plans to sign up only healthy beneficiaries. More than half of all Medicare fee-for-service beneficiaries cost less than $500 per year, while less than 5 percent of beneficiaries cost more than $25,000 per year. Some of these differences are predictable and should be taken into account in setting government payments fairly. Risk adjustment also helps eliminate overpayments that are built into the system due to disproportionate enrollment of healthy beneficiaries, according to the General Accounting Office. For these reasons, virtually all experts, including the MedPAC, support implementation of risk adjustment. The President's plan maintains the current phase-in schedule for risk adjustment that was announced in March.

Similarly, geographic adjustment of government payments helps protect beneficiaries and promote competition. The current Medicare Part B premium is set nationwide – all beneficiaries pay the same premium regardless of where they live. In contrast, government payments to private plans in different areas are adjusted by a complex formula involving "blended" national and local costs, historical costs, and statutory limits. Compared to payments based on local costs only, the blend included in the BBA increases private plan payments in low-cost rural areas, but reduces payments to private plans in high-cost areas. Under the proposed system, beneficiary premiums for managed care would no longer be fixed, but would vary based on plan prices. Since plan prices will implicitly include the local costs of care, if the government does not pay for these local costs, then the plan would pass through these costs to the beneficiaries in the form of higher premiums. This would make the beneficiary premium for managed care in high-cost areas much higher than that of the traditional program, discouraging enrollment. The full geographic adjustment of the government payments in high-cost areas included in this proposal is critical to making the competition between the traditional program and managed care premiums equitable. It is likely, however, that costs in these areas would fall as competition reduces unnecessary

utilization. The proposal would also keep the current partial geographic adjustment system for low-cost areas, maintaining the provisions included in the BBA to encourage private plans to enter rural areas.

3. Smoothing Out Balanced Budget Act Policies

Overview. The Balanced Budget Act of 1997 included important changes to Medicare payment policies that have contributed to restraining cost growth through 2002 and extending the life of the Medicare Trust Fund through 2015. The BBA policies were developed in consultation with Medicare experts, Congressional members and staff, and many outside interest groups. They include strong and defensible policies that will help preserve and protect Medicare for the people it serves. However, some of the approximately 335 BBA policy changes may have unintended consequences. Given how recently these changes were enacted, the implications for providers and beneficiaries are not clear. HCFA, MedPAC, GAO, and the HHS Inspector General are all engaged in proactive efforts to monitor the impact of the BBA policies on beneficiaries' access to quality health care. However, recognizing that there may be a need to adjust and gradually phase-in of some of the BBA policies, this plan includes set-aside funding for the purpose of making targeted adjustments to certain BBA policies. It also includes some administrative actions to smooth the transition for providers and a policy to help disproportionate share hospitals.

a. Quality assurance fund

Policy: The Medicare reform plan would set aside a stream of funding to make appropriate and justified modifications to BBA policies. This set-aside, totaling $7.5 billion for FY 2000-09, is funded in the context of the reform plan, but its uses are not specified. The Administration will work with Congress, Congressional advisory commissions, provider and beneficiary groups to determine what BBA policies, if any, have produced major access and quality problems for beneficiaries and/or made it excessively difficult for providers to deliver quality services. As we do so, we will develop with Congress specific policies that address problems in a fiscally prudent way. This process will be fact based and guided by evidence.

Background/rationale: The BBA implemented some of the most important changes to Medicare in the history of the program. Given the large number and magnitude of the changes, however, some issues have inevitably arisen. We are actively monitoring the impact of the BBA on beneficiary access to quality care. When we finalize our analysis of this information, we believe we will find that specific targeted changes should be made to assure that beneficiaries are receiving appropriate and high quality services.

Although some adjustments will likely be needed, the Administration wants to carefully evaluate evidence of problems and proposed policy solutions with the Congress, advisory groups like MedPAC, GAO and the Congressional Budget Office (CBO), and provider and beneficiary groups. We also intend to proceed with caution – the BBA represents an important, sound piece

of legislation that should only be moderated in certain instances, not undermined or repealed. The Administration will only support targeted changes to resolve specific problems with beneficiary access to quality care and will oppose legislation that risks opening up the BBA in a manner that significantly harms the Trust Fund and the Medicare program in general.

b. Administrative actions to smooth implementation of the BBA

Policy: The Administration will take a number of actions that are within its administrative authority under the statute to smooth the implementation of some of the provisions of the BBA. These changes will help ensure beneficiary access to care while maintaining the fiscal discipline of the BBA that is essential for protecting Medicare's future.

Inpatient hospital transfers. The BBA requires the Secretary to reduce payments to hospitals when they transfer patients to another hospital or unit, skilled nursing facility or home health agency for care that is supposed to be included in acute care payment rates for ten diagnoses. It also authorizes HCFA to extend this "transfer policy" to additional diagnoses after October 1, 2000. To minimize the impact on hospitals, extension of the transfer policy to additional diagnoses is being postponed for two years.

Hospital outpatient payments. The BBA requires Medicare to begin paying for hospital outpatient care under a prospective payment system (PPS), similar to what is used to pay for hospital inpatient care. To help all hospitals with the transition to outpatient prospective payment, we are considering delaying a "volume control mechanism" for the first few years of the new payment system. The law requires Medicare to develop such a mechanism because prospective payment includes incentives that can lead to unnecessary increases in the volume of covered services. The proposed prospective payment rule presented a variety of options for controlling volume and solicited comments on these options. Delaying their implementation would provide an adjustment period for providers as they become accustomed to the new system.

Also to help hospitals under the outpatient prospective payment system, we included a proposal in the proposed rule to use the same wage index for calculating rates that is used to calculate inpatient prospective payment rates. This index would take into account the effect of hospital reclassifications and redesignations.

We are considering implementing a three-year transition to this new PPS by making budget-neutral adjustments to increase payments to hospitals that would otherwise receive large payment reductions such as low-volume rural and urban hospitals, teaching hospitals, and cancer hospitals. Without these budget-neutral adjustments, these hospitals could experience large reductions in payment under the outpatient prospective payment system. For all of these outpatient department reform options, the rulemaking process precludes any definitive statement on administrative actions until after the implementing rule is published.

Rural hospital reclassification. Hospital payments are based in part on average wages where the hospital is located. We are making it easier for hospitals whose payments now are based on lower, rural area average wages to be reclassified and receive payments based on higher average wages in nearby urban areas and thus get higher reimbursement. Right now, facilities can get such reclassifications if the wages they pay their employees are at least 108 percent of average wages in their rural area, and at least 84 percent of average wages in a nearby urban area. We are changing those average wage threshold percentages so more hospitals can be reclassified.

Home health. The BBA significantly reformed payment and other rules for home health agencies. We are taking several new steps to help agencies adapt to these changes including: (1) increasing the time for repayment of overpayments related to the interim payment system from one year to three years, with interest. Currently, home health agencies are provided with one year of interest free extended repayment schedules; (2) postponing the requirement for surety bonds until October 1, 2000, when we will implement the new home health prospective payment system. This will help ensure that overpayments related to the interim payment system will not be an obstacle to agencies obtaining surety bonds; (3) following the recommendation of the General Accounting Office by requiring all agencies to obtain bonds of only $50,000, not 15 percent of annual agency Medicare revenues as was proposed earlier; (4) eliminating the sequential billing rule as of July 1, 1999. Many home health agencies had expressed concern about the impact of the implementation of this requirement on their cash flows and this measure should alleviate these problems to a large degree; (5) phasing-in our instructions implementing the requirement that home health agencies report their services in 15-minute increments in response to concerns that the demands of Y2K compliance were competing with agency efforts to implement this BBA provisions. By allowing this degree of flexibility for a temporary period we will prevent any agency cash flow problems or returned claims.

Background/rationale: The BBA required implementation of many changes on a rapid schedule, without fully taking into account the need to make Y2K computer changes and other implementation issues. Because of the magnitude of some of the changes, certain providers may need additional time to prepare or adjust to them. The plan includes these administrative actions to ensure that the implementation of the BBA changes is done in a way that simultaneously assures appropriate payment and access to high-quality health care.

c. Direct payments to disproportionate share hospitals (DSH)

Policy: Beginning in 2001, disproportionate share hospitals (DSH) payments associated with managed care enrollees would be removed from Medicare+Choice (i.e., managed care) payments and would be paid directly to hospitals on behalf of Medicare+Choice enrollees who are admitted to eligible hospitals, similar to the graduate medical education policy enacted in the BBA. This change would be budget neutral, and the total amount of DSH payments would be removed in the first year. The President's plan also includes a proposal to pay managed care plans based on their competitive prices beginning in 2003. When the competitive system is implemented, DSH payments, like graduate medical education payments, would not be included in the calculation of

the average traditional program costs that determines how much of the plan price the government pays (similar to the treatment of graduate medical education payments).

Background/rationale: Medicare makes an additional payment to hospitals that treat a high percentage of low-income patients. This is done through an adjustment to inpatient prospective payments to each hospital that qualifies for DSH payments. These payments are intended to support hospitals that serve a large number of uninsured persons, such as teaching hospitals and those in rural and inner-city areas where access is limited for low-income people. With recent hospital mergers and closures, Medicaid movement to managed care, and a competitive private marketplace, these payments are becoming even more important in ensuring access.

Studies have found that managed care typically does not pay disproportionate share hospitals the amount that they would have received if paid through fee-for-service. Given the important role that these hospitals play in serving the 43 million uninsured Americans, the President, as he has in the past, continues to support a policy that would pay DSH to these facilities directly they treat beneficiaries in managed care. By improving the targeting of these payments, this policy would help ensure that DSH payments serve their intended purpose.

4. Constraining Out-Year Medicare Spending Growth

Overview. This plan builds on the fiscal discipline that the Balanced Budget Act of 1997 brought to Medicare for 1998 through 2002 by including moderated policies to constrain Medicare spending growth beginning in 2003 through 2009 (the end of the budget window). The BBA would reduce Medicare spending per beneficiary to about 3.8 percent between 1998 and 2002, but after that, from 2002-2009, spending growth per beneficiary rises to 4.9 percent on average. The policies outlined below, along with the other policies in the proposal (excluding the drug benefit) would reduce Medicare spending per beneficiary to 4.3 percent over the 2002-2009 period. Payment rates for many Medicare services are determined by statutory formulas (e.g., fee schedules, prospective payment systems) that have annual updates to account for health care inflation. The growth in a "market basket" index of health care prices or the general consumer price index (CPI) are used for most services. Historically, Congress has reduced various update indices in many years to adjust for factors such as efficiencies gained by providers that are not reflected in their update factor. For example, over the past 15 years, the inpatient hospital market basket update has been reduced by –1.7 percentage points on average. This plan would adjust the annual update rates for some Medicare services using the same or lower reductions in updates as in the BBA. Recognizing concerns about excessive cost growth constraints, the proposal does not extend BBA policies for reducing growth in outpatient departments, disproportionate share hospitals, nursing homes, and home health.

a. Hospitals

Policy: The plan would make several adjustments to hospital payment policy.

Urban hospital inpatient payment update. The plan would update inpatient urban hospital payments by the hospital market basket minus 1.1 percentage point from fiscal year 2003 through 2009. While hospital payments are updated annually by a market basket index, the Medicare Payment Advisory Commission has projected hospitals' Medicare margins to continue to be at historically high rates. The BBA reduced the market basket update for all hospitals by 2.8 percentage points in 1998, 1.9 percentage points in 1999, 1.8 percentage points in 2000, and 1.1 percentage points in 2001 and 2002.

Rural hospital inpatient payment update. Rural hospitals serve an important role in areas where the next nearest hospital is often hours away. Recognizing this, the plan would update inpatient rural hospital payments by the hospital market basket minus 0.5 percentage points in fiscal 2003, and increasing the percentage point reduction by an additional 0.1 percentage point each year until the same update applies for rural and urban hospitals. As a result of their lower volume, however, they typically do not have as high Medicare margins as urban hospitals. The BBA reductions to the update did not differentiate between urban and rural hospitals.

Hospital capital payments. The plan would reduce reimbursement for prospective payment system (PPS) hospital capital costs by 2.1 percent from fiscal year 2003 through 2009. This is the same reduction as in the BBA.

PPS-exempt hospitals. When created in 1984, the inpatient PPS excluded certain specialty hospitals (e.g., psychiatric, cancer, children's and rehabilitation hospitals) because the PPS was thought to be a poor predictor of resource use in these hospitals. Their reimbursement formula is specified in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). The BBA changed this formula by creating national cost limits and reducing rate increases. Specifically, it moderated rate increases for PPS-exempt hospitals based on the relationship between a hospital's operating cost and its target amount. The plan would extend this reduction from fiscal year 2003 through 2009. It also would extend the BBA's 15 percent reduction in reimbursement for PPS-exempt hospital capital costs from fiscal year 2003 through 2009.

b. Ambulance, prosthetics and orthotics, and hospice services

Policy: The following payment update adjustments are continuations of the BBA policies.

Ambulance: The plan would increase ambulance payments at the rate of growth in the CPI minus 1 percentage point from 2003 through 2009.

Prosthetics and orthotics: The plan would increase payments for prosthetics and orthotics at the rate of growth in the CPI minus 1 percentage point from 2003 through 2009.

Hospice: The plan would increase hospice payments at the rate of growth in the hospital market basket minus 1 percentage point from fiscal year 2003 through 2009.

c. Ambulatory surgical centers

Policy: The BBA includes an update for payments for ambulatory surgical centers of the rate of growth in the CPI minus 2 percentage points in fiscal year 2002. The plan would increase payments for ambulatory surgical centers at the rate of growth in the CPI minus 1 percentage point from fiscal year 2003 through 2009. This would be an increase over the BBA, and would bring payment growth in line with most other Part B services.

d. Clinical laboratory services, durable medical equipment & parenteral & enteral items

Policy: The BBA includes a freeze on payments for clinical lab services, durable medical equipment, and parenteral and enteral nutrients supplies and equipment for 1998 through 2002. This plan would increase payments for these services at the rate of growth in the CPI minus 1 percentage point from 2003 through 2009. This would be an increase over the BBA, and would bring payment growth in line with most other Part B services.

Background/rationale: To ensure that program growth does not significantly increase after most of the Medicare provisions of the BBA expire in 2003, this package of proposal described above includes out-year policies that protect against a return to excessive growth rates but are more moderate than those included in the BBA. These proposals, in combination with the modernization of traditional Medicare and competition, would reduce average annual Medicare spending growth from 4.9 percent to 4.3 percent per beneficiary between 2002 and 2009 – over 10 percent higher than the BBA spending growth per beneficiary for 2002-2009.

5. Improving Medicare Management, Including Public/Private Advisory Boards

Overview: The President's plan includes a major modernization reform of the management of the Health Care Financing Administration (HCFA) which oversees Medicare. These proposals, which are included in the President's FY 2000 budget along with others such as reforming the regional and central office relationships, are designed to better integrate private sector experiences and practices into the Medicare program. These efforts will also allow HCFA to better and more efficiently manage its increasing workload while improving the already high level of service and quality of care for our beneficiaries.

a. Increasing accountability through public/private advisory boards

Policy: HCFA will improve its services and increase its accountability. It plans to establish three key private/public advisory panels to help in this effort.

- Management Advisory Council. Private and public sector experts will help HCFA identify, adapt, and adopt innovations in customer service, purchasing, and management. The Council

will help HCFA improve service and strengthen accountability by creating a conduit to private sector expertise and holding public meetings to air Medicare management issues.

- Medicare Coverage Advisory Committee. Experts in medicine and science, along with consumer and industry representatives, will help guide a new open, understandable, and predictable process for determining whether treatments and devices should be covered by Medicare. The Committee and new open process will improve service and strengthen accountability by holding public meetings, setting timetables, and posting information on pending coverage issues on the Internet.

- Citizens Advisory Panel on Medicare Education. Experts in medicine, health policy, and consumer education would help make sure beneficiaries have timely, understandable and useful information about their rights and options in Medicare. The Panel will improve service and strengthen accountability by establishing a public forum for continual feedback on how education efforts are faring and what should be done to improve them.

b. Increasing personnel flexibility

Policy: HCFA has made new and significant strides in hiring highly qualified professionals with private sector backgrounds. However, HCFA needs greater personnel flexibility to have the right staff to stay on top of changes in the rapidly evolving health care marketplace, to increase its purchasing expertise, and to hold staff accountable for results. HCFA has contracted with independent experts to evaluate staffing needs and how well HCFA staff currently meets those needs. Their findings will help determine exactly what legislative or other changes are needed to make sure the right people are in the right places to ensure beneficiaries have access to high quality health care services.

II. MODERNIZING MEDICARE'S BENEFITS

1. Prescription Drug Benefit

Overview. This proposal would create a new and voluntary outpatient Medicare prescription drug benefit that is accessible and affordable to all beneficiaries. Medicare beneficiaries would have the option to enroll in "Part D" of the program. All Part D beneficiaries would immediately be able to purchase their prescriptions at the lower drug prices which private-sector benefit mangers are able to negotiate. In addition, the new benefit would have no deductible and would pay half of participants' drug costs up to a limit of $5,000 ($2,500 in Medicare payments) when fully implemented. Medicare would also provide a 50 percent premium subsidy for this coverage to assure that it is affordable for all beneficiaries. Its premiums are estimated to be $24 in 2002 and $44 in 2008 when fully implemented. Low-income beneficiaries (below 135 percent of poverty) would not pay for premiums or cost sharing (improving the protections that they have for the Medicare Part B premium), and those between 135 and 150 percent of poverty would pay

a reduced premium. Enrollees in Medicare managed care plans would receive their benefit as they do today – although plans, for the first time, would be paid directly for providing this coverage. Beneficiaries in the traditional program would get their benefits through private pharmacy benefit managers (PBMs) or other qualified entities. Medicare would contract out for this management through competitive bidding similar to that used by most private insurers and large employers. This proposal also includes incentives to develop and retain employer-provided retiree drug coverage.

Despite the indisputable importance of prescription drugs to health care today, Medicare does not explicitly cover outpatient prescription drugs. As a consequence, nearly 15 million Medicare beneficiaries lack drug coverage altogether – many of whom are middle income. Millions more have retiree health coverage, which is declining; Medigap, which is unstable and increasingly expensive; Medicaid, which restricts eligibility to the lowest income seniors and people with disabilities; or Medicare managed care. Medicare manage care plans are restricting their extra benefits, including prescription drugs, reinforcing the need for a minimum, national drug benefit option for all Medicare beneficiaries.

a. Benefit design

Policy: There are several major design features of the prescription drug benefit:

- No deductible: Coverage would begin with the first prescription.

- Discounts: From the first prescription on, beneficiaries would get the same discount that the private group purchaser who manages the benefit gets. This discount would continue even after the benefit limit is reached.

- Coinsurance: Beneficiaries generally would be responsible for coinsurance amounting to 50 percent of the cost of any prescription. Benefit managers would be allowed to reduce the coinsurance charged to beneficiaries if they could demonstrate as part of their bid proposal that they could achieve savings without undermining quality health care and access to needed medications.

- Benefit limit: There would be a limit on total amount of spending that the plan would pay each year on behalf of a particular beneficiary. The limit would be set at $2,000 ($1,000 in Medicare payments) for calendar years 2002 and 2003; $3,000 for 2004 and 2005; $4,000 for 2006 and 2007, and $5,000 for 2008. In 2009 and subsequent years, the limit would be increased each year by the increase in the consumer price index (CPI).

In general, all therapeutic classes of drugs would be covered under the Medicare Part D benefit. In addition, beneficiaries would be guaranteed access to off-formulary drugs when medically necessary, and have basic appeal rights where coverage is denied. The only exceptions would be the set of drug classes currently excluded under Medicaid (Title XIX) (including drugs for weight

loss or gain, promoting fertility, cosmetic purposes or hair growth, symptomatic relief of cough or colds, prescription vitamins and minerals, and all nonprescription drugs), except that prescription smoking cessation drugs not covered under Title XIX would be covered under Medicare Part D. Prescription drugs currently covered under Medicare Part A or B would still be covered under current arrangements and would not be counted against the Part D benefit limit. If there are drugs for which there have been documented abuses, benefit managers would be permitted to take certain measures to assure appropriate utilization, as is the case in both private sector and Medicaid prescription drug programs. No formulary would be established by the Medicare program, but private benefit managers could establish formularies, subject to the coverage requirements (described below), as virtually every PBM and private insurer does today. This would help them negotiate better prices and evaluate optimal therapeutic interventions. Benefit managers would also be authorized to create appropriate incentives for generic substitution, a practice widely used in private plans today.

Background/rationale: This benefit would provide meaningful coverage to all beneficiaries regardless of their level of drug utilization. Because of the zero deductible, beneficiaries would be covered from their first prescription each year. The 50 percent coinsurance would help to make the coverage affordable to the government and beneficiaries through lower premiums, and would help guard against overutilization. The cap on total benefit payments helps keep the program affordable for taxpayers. Over 90 percent of beneficiaries would not reach the cap when fully implemented.

This benefit is designed to assure beneficiaries have access to needed drugs while allowing private managers set procedures for accessing drugs. This flexibility allows the Medicare drug benefit to adapt to future pharmaceutical advances without major new legislation or regulation.

b. Financing

Policy: In general, the new Medicare prescription drug benefit would be operated as a separate part of the Supplemental Medical Insurance (SMI) Trust Fund. Using this Trust Fund would eliminate the additional bureaucracy associated with a new trust fund. In no way would Part D costs or income affect Part B costs or premiums. The beneficiaries and government would equally split the cost of the Part D benefit. Thus, beneficiaries would pay a premium in the amount of 50 percent of the cost of the program. The estimated premium in 2002 is $24 per month, rising to $44 per month in 2008 when the benefit is fully phased in. Beneficiaries would also pay cost sharing, as described above.

Premiums for those beneficiaries opting for Part D coverage would be collected in the same way as Part B premiums, as a deduction from Social Security checks for most beneficiaries. Once enrolled, beneficiaries would be notified of the annual premium in the same notice in which they learn about the Part B premium for the next year.

Background/rationale: The Part D prescription drug benefit is financed on a shared voluntary

basis, similar to the structure of Medicare Part B. Financing will be split between beneficiaries and government (each pays 50 percent of the full premium). This level of subsidy is designed to keep premiums low enough to be affordable to beneficiaries and to avoid risk selection (see section III-2 for a description of the offsets for this benefit).

c. Enrollment

Policy: In general, beneficiaries would have a one-time opportunity to sign up for the voluntary benefit, in either the first year the benefit is offered (2002) or their first year of Medicare eligibility. There are two exceptions: (1) beneficiaries who are covered by their employer while still working (or by the employer of a working spouse) have a one-time opportunity to enroll after retirement (or retirement or death of the working spouse); and (2) beneficiaries who are covered by employer-based retiree coverage have a one-time opportunity to enroll if the former employer drops coverage of prescription drugs for all retirees.

In the first year of implementation, all Medicare beneficiaries would be able to sign up for the benefit during an open enrollment period, held at the same time as the Medicare+Choice enrollment period in November 2001. During 2001, the Medicare program would conduct a major education campaign about the new benefit option. After the first year of implementation, all newly eligible Medicare beneficiaries could enroll for the optional Part D coverage, under the same procedures as established for enrollment in optional Part B coverage.

Background/rationale: Similar to Medicare Part B, enrollment in Medicare Part D is done on a one-time only basis. This approach is critical to reducing or eliminating selection bias; if enrollment were allowed on an annual basis, beneficiaries could make the decision to select coverage only for years in which they anticipate high drug costs. Beneficiaries who have adequate employer-sponsored coverage could continue that coverage without paying twice for the same benefit. The exceptions are designed to ensure that beneficiaries with employer-sponsored coverage are protected if that coverage becomes unavailable.

d. Management, payments, and beneficiary protections

Policy: Medicare would not administer this benefit directly, but instead contract out with private sector entities. This could include pharmacy benefit managers (PBMs), retail drug chains, health plans or insurers, states (through mechanisms established for Medicaid), or multiple entities in collaboration (e.g., alliances of pharmacies), provided that the collaboration increases their scope or efficiency and is not anti-competitive.

Private benefit managers would competitively bid to manage the benefit for a particular geographic area. The number and boundaries of the geographic areas designated should be set to ensure that multiple entities would have an opportunity to compete for the single contract

awarded in each area and that enrollment in each area is large enough to encourage efficiency. At the same time, rules would be established to assure that a few private benefit managers do not dominate the Medicare market and that there are multiple areas.

Competition for contracts to administer the Part D benefit would be held periodically, probably every two or three years. The Secretary would develop specific criteria for selecting the winning entities, and would solicit bids in response to these criteria. In general, Medicare would follow the best practices of large private employers and plans, including consultation and recommendations from benefits experts. The selection process would consider the entity's administrative fees, as well as its clinical quality programs, its formulary, information and management systems, the likely ability of the entity to control drug costs for beneficiaries and government, disease management programs, relationships with drug manufacturers, and other factors. Any entity that meets a set of criteria (described below) would be eligible to compete for the contracts.

All PBMs or other entities would be required to meet access and quality standards established by the Secretary. These standards would include (but are not limited to): inclusion of strategies to encourage appropriate use of medications; use of a medical panel with outside experts free of conflicts of interest in creating the formulary; use of objective criteria in selecting drugs for the formulary; open and fair dealing with all drug and biologic companies; publication of criteria for any cost containment measure that could affect patient care; submission of data about costs and utilization on a regular basis to help improve quality of care; compliance with standards for capacity and pharmacy availability to serve all beneficiaries in the geographic area; and compliance with contract requirements and consumer protections, including grievance and appeals procedures, that apply to Medicare+Choice plans to the extent that these requirements are relevant. No balance billing could be collected by the pharmacy. We would also require that, once beneficiaries have exceeded their benefit caps, that they would continue to have access to prices established by the benefit manager.

Private benefit managers could use various cost containment tools in administering the program, subject to limitations and guidelines in the contract. Benefit managers would be required to negotiate with pharmacies that meet a set of qualifications, including having the necessary information systems to process electronic point-of-sale transactions and create utilization records. Dispensing fees would have to be high enough to ensure participation by most pharmacies. They would also be required to use drug utilization review programs and meaningful clinical criteria to assure quality.

The government would bear most of the risk for the cost and utilization of services under the prescription drug benefit. The PBM serving each geographic area would be paid a fee for managing the benefit, and would have some contractual incentives to control cost and utilization. The Medicare program would test the use of various arrangements such as bonuses (retaining portion of discounts they arranged), withholds, or risk corridors to provide incentives to the private benefit managers to manage the benefit effectively.

Under this proposal, Medicare would not set prices for drugs. Prices would be determined through negotiations between the private benefit administrators and drug manufacturers. Thus, the proposal differs from the Medicaid program in that a "rebate" would not be required and from the Veterans' Administration program in that no fee schedule for drugs will be developed. Instead, the competitive bidding process would be used to yield the best possible drug prices and coverage, just as it is used by large private employers and the Federal Employees Health Benefit Plan today.

Medicare+Choice plans would be required to provide a prescription drug benefit for all enrollees who have elected to participate in Part D. Those beneficiaries enrolled in Medicare managed care plans would receive their drug benefit through their plan and the government would explicitly subsidize this coverage. Like the Part B premium, which would be based on the plan's price, this Part D premium would be competitively set. If beneficiaries leave a Medicare+Choice plan and return to fee-for-service Medicare, they would receive their Medicare Part D benefit through the contracting PBM for their geographic area.

Background/rationale: The Part D benefit would rely on administration by private entities, such as PBMs. Beneficiaries enrolled in managed care plans would receive a drug benefit from that plan which would receive a government payment for that coverage. Beneficiaries in traditional Medicare would get their benefits through private benefit managers. This approach mirrors the administration of most private insurance programs, which increasingly use PBMs or similar organizations to administer their drug benefits. These organizations have experience managing drug utilization and have developed numerous tools for cost containment and utilization management. Contracting with multiple private entities, each with claims processing and program management experience, will increase Medicare's ability to run this benefit smoothly. The number of contracts and the number of years in the contracting cycle will be set by the Secretary at levels that will help attract existing PBMs to this program and that will encourage new entrants into this market.

Private benefit managers would have the authority to use the tools that are commonly used for managing drug costs and utilization in the private sector, subject to basic standards set by Medicare. In particular, Medicare would require drug utilization review to help ensure that adverse drug interactions are prevented, that proper drug protocols are followed, and that compliance by patients is monitored. A key goal would be to reduce unnecessary hospitalizations and adverse drug events where possible.

In today's private-sector marketplace, PBMs do not typically accept full risk for the management of drug benefits. To be consistent with market practices and to assure that PBMs participate, Medicare would share only limited risk in its contracts. To provide some incentive for managing utilization and costs, Medicare would establish performance bonuses or other means of rewarding benefit managers that manage the benefit effectively.

The program would also establish certain basic beneficiary protections, an essential feature of any health program. Adequate access to a pharmacy network should be ensured since benefit

managers are required to contract with all qualifying pharmacies. In addition, beneficiaries would be guaranteed access to off-formulary drugs when medically necessary, and have basic appeal rights where coverage is denied.

e. Expanded assistance for low-income beneficiaries

Policy: This plan would build on current Medicaid protections for low-income beneficiaries to assure that they have access to the new prescription drug benefit. The new Part D program would be treated like Part B for beneficiaries in the qualified Medicare beneficiary (QMB) program. This means that Medicaid would pay for drug premiums and cost sharing for beneficiaries up to 100 percent of poverty, using the current Medicaid matching rate. Additionally, the proposal would create two new eligibility categories. First, beneficiaries with incomes between 100 and 135 percent of poverty would, like QMBs, receive full assistance for their drug premiums and cost sharing. However, the Federal matching rate would be 100 percent. Second, beneficiaries with incomes between 135 and 150 percent of poverty would pay a partial, sliding-scale premium based on their income. The Medicaid costs for this group would also be matched at 100 percent. States would be obliged to offer this expanded protection.

All states would have some fiscal relief as a result of this benefit since they all provide prescription drug coverage to dual eligible Medicaid-Medicare beneficiaries. The current qualified Medicare beneficiary (QMB), specified low-income Medicare beneficiary (SLMB), and qualified individual (QI) programs would continue as under current law to provide assistance for Part B premiums and cost sharing.

Background/rationale: Low-income beneficiaries tend to have disproportionately high drug costs. An AARP study found that beneficiaries with incomes below $10,000 spent an average of 8 percent of their income for drugs. For those with a severe illness or a need for a new, high-cost drug, the costs can be devastating. Only those beneficiaries who are very poor or who, because of severe health problems, qualify for Medicaid which covers prescription drugs.

Medicaid does, however, pay for Medicare Part B premiums and cost sharing for certain low-income beneficiaries. This coverage, which was expanded by the Balanced Budget Act, would be further enhanced under this proposal. Federal funding would be available to states to ensure that all poor and near-poor beneficiaries pay no premiums or cost sharing for this coverage.

f. Incentives to develop and retain employer-provided retiree drug coverage

Policy: The policy is designed to encourage and support the development and retention of employer-sponsored retiree health benefits. It is the intention of this policy to make certain that current coverage for prescription drugs in retiree health plans is not lost or diminished. The Administration will work closely with employers, unions, and other interested parties to make certain that this goal is met.

Under this policy, Medicare would provide a partial drug premium subsidy to employers whose retiree coverage is at least as good as the Medicare benefit. The Medicare contribution would be 67 percent per beneficiary of the subsidy that it would otherwise provide for Medicare Part D enrollees. As such, Medicare would save 33 percent of its costs for each beneficiary in private employer-based retiree coverage.

This incentive payment would operate through the health plan or PBM that administers an employer's drug benefit, as follows. First, on an ongoing basis, the health plan or PBM would document for HCFA all retirees for whom they are providing employer-sponsored drug benefits. HCFA would use these lists to designate beneficiaries who should not be charged the Part D premium and which employers are eligible for the employer subsidy.

Second, the employer health plan or PBM would attest, at the outset and on an annual basis, that their drug benefit meets minimum standards (e.g., is as generous as the Medicare benefit and is offered to all retirees in a manner that does not discriminate based on factors such as age or health status). The standards would be analogous to those required of Medicare+Choice plans.

Third, HCFA would make the premium subsidy payments to the health plan or PBM that administers the drug benefit on behalf of the employer, so that the employer's payment is reduced. Because the PBMs and private plans used by employers to administer their drug benefits will generally be participating in Medicare, the subsidies would generally go to entities that are already receiving payments from HCFA.

If the employer drops retiree coverage, beneficiaries who were covered would have a one-time opportunity to enroll in Medicare Part D.

Background/rationale: Less than 30 percent of Medicare beneficiaries today get coverage through their former employers. This type of coverage has been eroding in recent years. Between 1993 and 1997, the percent of large firms offering retiree health benefits for Medicare eligibles dropped 20 percent. This provision is designed to create an incentive to keep employers in this market by making a payment to the employers (or the plans or PBMs that manage their drug benefits) and possibly encourage others to offer. The incentive payment is lower than what the government's costs would be if the employer coverage was dropped. Because the employer contribution to the drug benefit is tax-deductible, this policy provides an additional incentive for employers to provide coverage, allowing employers to offer the same or more generous drug benefits at a significantly lower net cost.

2. Improving Preventive Benefits and Eliminating Cost Sharing

Overview. Older Americans are the fastest growing age group in the United States, with an increasing number of older Americans surviving to age 85 and older. They carry the greatest risk of dying from cancer and heart disease as well as the highest rates of chronic disease and

disability. For example, 88 percent of those over the age of 65 have at least one chronic health condition, and large numbers of older adults suffer from impaired functioning and well-being. Early detection, risk factor reduction, and health screening programs and appropriate follow-up care can result in a significant reduction in morbidity.

a. Eliminating all preventive services cost sharing

Policy: This proposal would waive the Part B deductible and 20 percent coinsurance rate for preventive services for which cost sharing is not already waived under current law. The deductible would be waived for hepatitis B vaccinations, colorectal cancer screening, bone mass measurements, prostate cancer screening and diabetes self-management benefits. Coinsurance would be waived for screening mammography, pelvic exams, hepatitis B vaccinations, colorectal screening, bone mass measurements, prostate cancer screening and diabetes self-management benefits. For the rest of the preventive services covered by Medicare, cost sharing is already waived.

Background/rationale: The Balanced Budget Act of 1997 added many new preventive benefits (e.g., colorectal cancer screening and diabetes self-management training). According to recent studies, Medicare preventive services are underutilized. For example, the 1999 Dartmouth Atlas of Health Care found that, in 1995-1996, only one in four women in their sixties were tested as often as recommended for breast cancer. In the first two years that Medicare covered screening mammography, only 14 percent of eligible women without supplemental insurance received a mammogram. Waiving cost sharing for preventive benefits should increase utilization of these services.

Current Law Cost-Sharing Requirements for Medicare Preventive Benefits

Benefit	Deductible	20% Coinsurance
Screening Mammography	Waived	Applies
Pap Smear – Lab Test	Waived	Waived
Pap Smear – Physician Exam	Waived	Applies
Flu Vaccinations	Waived	Waived
Pneumonia Vaccinations	Waived	Waived
Hepatitis B Vaccinations	Applies	Applies
Colorectal Cancer Screening		
Fecal Occult Blood Lab Test	Waived	Waived
Other Procedures	Applies	Applies
Bone Mass Measurements	Applies	Applies
Diabetes		
Glucose Monitors & Test Strips	Applies	Applies
Self-Management Training	Applies	Applies
Prostate Cancer*		
PSA Lab Tests	Waived	Waived
Other Screening Procedures	Applies	Applies

*****Medicare will cover these benefits beginning on January 1, 2000.

b. Information campaign on prevention

Policy: The Department of Health and Human Services (HHS) would launch a two year, nationwide education campaign beginning in 2001 to promote the use of preventive health services by older Americans and people with disabilities. The campaign would have three parts:

- Educating all Americans over age 50 and people with disabilities about the importance of preventive health care. The Department of Health and Human Services, the Social Security Administration, and private sector partners would combine public service announcements and a print media campaign to raise awareness of the value of prevention. HHS would distribute brochures and other information on health promotion and disease prevention activities through the State Health Insurance Assistance Programs and the Area Agencies on Aging. HHS would also place brochures in the Social Security Administration's (SSA) 1,300 field offices. SSA would include information on the importance of preventive health care on the Cost Of Living Adjustment (COLA) notice, which is sent to the approximately 6 million people with disabilities who receive SSA or SSI benefits. Information on the importance of preventive health care will also be included on the Personal Earnings and Benefit Estimate Statement and in currently produced brochures on retirement and survivors' benefits. Finally, SSA would expand the section in its Medicare brochure to include a fuller discussion of the importance of health promotion activities and the benefits offered under Medicare.

- Encouraging Medicare beneficiaries to use its preventive benefits. This campaign would

provide Medicare beneficiaries information about the importance of regularly receiving preventive health care benefits, such as vaccinations and mammograms, and would encourage individuals to access these benefits under Medicare. This would be done in several ways:

- *Distribute comprehensive information on preventive benefits to all 39 million Medicare beneficiaries.* HHS would (1) expand the section on preventive benefits in the *Medicare and You* handbook to include information on the importance of receiving mammograms, diabetes monitoring, colorectal cancer screening, bone mass measurements, and regular vaccinations; (2) instruct fiscal intermediaries and carriers to include preventive benefits messages on the Medicare Summary Notice statement and the Explanation of Medicare Benefits; (3) include prevention messages regularly on the Medicare Part B benefits statement; and (4) work with the other agencies and the private sector, including senior centers, the Cooperative State Research Education and Extension Service, the Meals on Wheels programs, and religious organizations, to deliver information to Medicare beneficiaries about the importance of preventive benefits and which ones are covered under the Medicare program.

- *Development of health status assessment tool for Medicare beneficiaries*. HCFA, together with the Centers for Disease Control (CDC) and Agency for Health Care Policy and Research (AHCPR), would develop a health status assessment tool for beneficiaries. This self-assessment tool would help the beneficiary identify important health information, risk factors, or significant symptoms that should be acted upon or discussed with their health care provider. HHS would train the State Health Insurance Assistance Program staff to assist Medicare beneficiaries with the completion of the self assessment form so that they can raise the health issues identified to their health care provider.

- Launching an education and awareness campaign to prevent falls in the elderly. HHS would launch a nationwide campaign to educate older Americans about the best way to modify their home environment in order to avoid potentially harmful and debilitating falls. The campaign would utilize radio advertisements and print media, and would emphasize the following messages: use anchor rugs; minimize clutter on floors; use nonskid mats; install handrails in bathrooms, halls, and along stairways; light hallways, stairwells, and entrances; and wear sturdy shoes.

Background/rationale: Loss of function can begin for people in their 50s, arguing for preventive approaches starting in middle age as a means of promoting health and limiting disability in the later years of life.

Increasing the venues through which Medicare beneficiaries and older Americans will be educated about the importance of preventive benefits and how to access them under the Medicare program will increase the likelihood that beneficiaries will use these services. A recent study indicates that Medicare beneficiaries do not understand that Medicare covers preventive benefits. Almost 70 percent of beneficiaries who stated that they knew about the range of Medicare services were unable to answer questions about Medicare's coverage of preventive benefits correctly.

However, studies indicate that repeated short, simple, print media messages enhance the target population's recall and retention of health promotion messages. These messages have also been shown to have a greater impact on individuals at higher risk.

In addition to educating beneficiaries about the importance and availability of preventive services, this proposal would address one of the major public health problems facing the elderly: the high incidence of falls. In 1995, more than 7,700 people over the age of 65 died as a result of a fall. For people aged 65 to 84, falls are the second leading cause of injury-related death; for those aged 85 or older, falls are the leading cause of injury-related death. Falls are the most common cause of injuries and hospital admissions for trauma among the elderly, accounting for 87 percent of all fractures among people aged 65 years or older and are the second leading cause of spinal cord and brain injury. For people aged 65 years or older, 60 percent of fatal falls occur in the home. This education campaign aims to reduce the risk of falls, thereby improving the quality of life and reducing Medicare costs.

c. U.S. Preventive Services Task Force study on new preventive services for older Americans

Policy: The Secretary would direct the U.S. Preventive Services Task Force to conduct a series of new studies to identify preventive interventions that can be delivered in the primary care setting that are most valuable to older Americans. In addition, it would include evaluation of services of particular relevance to older Americans in the mission statement of the Task Force.

Background/rationale: Despite the potential for preventive services to improve the quality of life for older Americans, few clinical guidelines focus on preventive care for older Americans.

The U.S. Preventive Services Task Force, an independent panel of preventive health experts, together with the Agency for Health Care Policy and Research, is charged with evaluating the scientific evidence for the effectiveness of a range of clinical preventive services, including common screening tests, immunizations, and counseling for health behavior change and producing age-specific and risk-factor-specific recommendations for these services. The task force focuses primarily on preventive interventions that can be delivered in the primary care setting, are widely available, and for which scientific evidence exists to assess efficacy and effectiveness.

d. Demonstration of smoking cessation drugs and counseling

Policy: HCFA would launch a demonstration project to evaluate the most successful and cost-effective means of providing smoking cessation services to Medicare beneficiaries, including testing incentive systems for both providers and beneficiaries to optimize "quit" rates. The demonstration would be based on the latest scientific evidence regarding smoking cessation strategies and guidelines. These guidelines suggest that the most effective smoking cessation strategies include an initial patient assessment, counseling services, and nicotine replacement therapy. Non-Medicare providers could participate in the demonstration since part of its purpose will be to determine the most cost-effective providers for delivering smoking cessation services. Medicare rules would be waived to the extent necessary to allow such providers to bill for these services. Providers would be reimbursed for the lesser of 100 percent of the cost of the service or the amount determined by a fee schedule established by the Secretary.

Background/rationale: The four leading causes of death – heart disease, cancer, cardiovascular disease, and chronic obstructive pulmonary disease (COPD) – are strongly related to smoking. The risk of death due to coronary heart disease in smokers is two to four times greater than in non-smokers; the risk of stroke is 1.5 times greater in smokers than in non-smokers; and mortality and serious morbidity related to COPD occurs almost exclusively in smokers. Studies from the last three decades have shown that when people stop smoking, their risk of tobacco-related morbidity and mortality decreases significantly. For example, the risk of myocardial infarction (heart attack) diminishes by almost one third after the first year of smoking cessation and reaches the level of people who have never smoked by the third or fourth year of quitting. In addition to its health benefits, smoking cessation may reduce costs.

3. Rationalizing Cost Sharing and Medigap

a. New 20 percent coinsurance on clinical laboratory services

Policy: For most other Part B services, beneficiaries are subject to both a deductible and the 20 percent coinsurance rate. However, Medicare currently pays 100 percent of the approved fee for clinical laboratory services provided to beneficiaries. This policy would apply 20 percent coinsurance requirements to all clinical laboratory services beginning in 2002. This coinsurance requirement would not apply to lab services which are also preventive services (e.g., pap smears and fecal occult blood lab tests for colorectal cancer screening).

Background/rationale: Clinical laboratory services represents a fast-growing Medicare service. About 24 million beneficiaries used diagnostic lab service in 1997, at a rate of about 14 services per user and an annual cost of $200 per user. Having beneficiaries contribute towards their lab services would make cost-sharing requirements under Part B more uniform and easier to understand. It also could cut down on fraud and help reduce over-use.

b. Indexing the Part B deductible to inflation

Policy: Medicare's Part B deductible of $100 would be indexed annually to inflation beginning in 2002. Given current inflation projections, this policy would increase the deductible by $2-$3 per year.

Background/rationale: The Part B deductible (i.e., the amount that enrollees must pay for services each year before the government shares financial liability) is set at $100 a year. In relation to average annual per capita charges under the SMI program, the deductible has fallen from 28 percent in 1967 to about 3 percent (projected) for 2000. The deductible has been increased only three times since Medicare began in 1966, when it was set at $50. Rather than follow past practice of instituting a one-time increase of 20-33 percent, this policy would make small, annual adjustments to guard against the program assuming a growing amount of Part B costs.

c. Updating and expanding Medigap plan options

Policy: This policy would request that the National Association of Insurance Commissioners (NAIC) create a new Medigap plan option that has more rational cost sharing than the current standardized plans. The plan option would protect beneficiaries against catastrophic costs while maintaining nominal cost sharing to discourage unnecessary use of health care services. This new Medigap plan would simply provide another option for beneficiaries; those who wish to continue their current Medigap coverage would not be affected. All Medigap carriers would be required to offer this policy, which would likely be less expensive than other plan options because of its nominal cost sharing.

It would also authorize the Secretary, in consultation with the NAIC, to review the standard Medigap packages on a periodic basis to determine whether any changes should be made to the content or number of the packages. The proposal would also conform Medigap benefits to the changes in this reform plan.

Background/rationale: Medigap plans typically eliminate all cost sharing for most Medicare services. As a consequence, beneficiaries face no immediate cost for using health care services. One study found that Medicare spending for beneficiaries with Medigap coverage was 29 percent higher than that of beneficiaries with no coverage, and 11 percent higher than that of beneficiaries with retiree health coverage (which typically has some cost sharing). Additionally, the premiums for Medigap have been rising rapidly – over 10 percent per year according to some sources. A policy with limited cost sharing could be less expensive and thus more affordable than the current plan options while still protecting beneficiaries from high out-of-pocket costs.

The ten standard Medigap packages were created as a result of OBRA '90. This proposal would authorize a review of the packages, most notably the drug benefit provisions. In particular, the Secretary and NAIC would examine the feasibility of providing additional drug coverage through

a Medigap plan that provides both additional protection above the limit and reduces the coinsurance rates for coverage below the limit. The establishment of a Preferred Provider Option (PPO) within traditional Medicare also has implications for Medigap. The Secretary and the NAIC would also continue their current efforts to improve the information available to beneficiaries about their Medigap options, similar to the current HHS efforts to provide beneficiaries with easy-to-compare information on their options for basic Medicare benefits.

d. Report to Congress on policy options for supplemental coverage

Policy: The Secretary of Health and Human Services would be directed to produce a detailed report to Congress on policy options for improving supplemental coverage for Medicare beneficiaries, with a special focus on limiting out-of-pocket spending for Medicare-covered services. This report would examine issues associated with having multiple sources of insurance (e.g., duplication of coverage, incentives to overuse care) and compare Medicare's cost sharing to that of a typical private-sector health insurance plan. It would also present options and recommendations on ways to improve beneficiary information on the cost and quality of Medigap; the feasibility and advisability of Medicare offering an unsubsidized option to limit out-of-pocket spending; and whether and how to structure the supplemental benefits that private plans could offer (without subsidies) in the new competitive defined benefits system.

Background/rationale: Because Medicare does not protect against high out-of-pocket health spending, about 90 percent of Medicare beneficiaries have some second (or third) source of health insurance. Some of these beneficiaries get supplemental coverage through Medicaid or Medicare managed care, while about 30 percent purchase private Medigap plans. Medigap premiums vary tremendously and can be quite costly. Individual insurance typically has a mark-up for administrative expenses and profit of 30 percent. In contrast, private group plans, the mark-up is about 10 percent and Medicare administrative expenses are less than 2 percent. Additionally, Medigap totally eliminates cost sharing, which could encourage overutilization. Studies have documented that people with Medigap tend to have higher use and costs relative to people with retiree coverage, which has some cost sharing. The accessibility and affordability of supplemental insurance also appears to be declining. A study of trends between 1992 and 1996 found that the premiums of the most popular Medigap plans experienced nearly double-digit inflation. In recent years, Medigap coverage has declined, although this has been somewhat offset by increased Medicare managed care enrollment. Similarly, retiree health coverage is declining. Between 1993 and 1997, the percent of large firms offering retiree health benefits dropped by about 20 percent. As such, private supplemental coverage as it is currently offered may become more inaccessible in the future.

Possible approaches to reducing costs and improving coverage include a mechanism for Medicare to provide standardized, understandable information on Medigap plans to beneficiaries, much as Medicare is doing to improve competition and reduce costs of private plans, and having Medicare offer unsubsidized Medigap coverage. This study would be conducted in conjunction with the proposals for updating private Medigap options discussed above.

e. Access to Medigap

Policy: The President's budget includes several policies that would improve access to Medigap for beneficiaries whose private plans have withdrawn from Medicare. They include:

- Initial Open Enrollment for Medigap for Disabled and end-stage renal disease (ESRD). Under current Federal law, only aged beneficiaries have an initial open enrollment period for Medigap. Eighteen States mandate an initial open enrollment period for beneficiaries under 65 (although one of these states does not include individuals with ESRD). This proposal would expand the initial 6-month open enrollment period to new disabled and ESRD beneficiaries. It would mandate that insurers who write policies for new aged beneficiaries offer these same policies to new disabled and ESRD beneficiaries. Enactment of this proposal would assure Medigap access in all states for disabled and ESRD beneficiaries both upon initial eligibility for Medicare and also in the case of Medicare+Choice plan termination. This proposal would be effective upon enactment.

- Special Medigap Open Enrollment Period for Certain Beneficiaries. The BBA provided that beneficiaries in plans that terminated their Medicare contract or reduced their service area have a 63 day open enrollment period for Medigap. The provision was triggered for the first time by plan terminations and service area reductions effective January 1, 1999. Unfortunately, given the newness of this provision, some insurance carriers were not properly prepared to answer inquiries regarding this new right. This proposal would provide a one-time additional special Medigap open enrollment period for individuals who were enrolled in a plan and who had no Medicare+Choice option after the plan terminated its contract or reduced its service area effective January 1, 1999. The special enrollment period would begin upon enactment and would last for 90 days.

- Expand Choice of Medigap Plans During Special Enrollment Periods. The BBA provided special enrollment opportunities for Medigap under certain situations (e.g., for an enrollee of a Medicare+Choice plan whose plan terminates its contract or reduces its service area). Under current law, however, beneficiaries in these situations only have access to plans "A","B","C" and "F", none of which include coverage of prescription drugs. This proposal would expand the BBA special open enrollment opportunities to include access to all Medigap options, including those that offer prescription drugs, offered to new enrollees. This proposal would be effective upon enactment.

- Increase Civil Monetary Penalties for Violation of Medigap Open Enrollment Requirement. Issuers who violate the open enrollment requirement are subject to a civil monetary penalty (CMP) of $5,000 for each violation. This proposal would increase the CMP for failure to $50,000 for each violation plus $5,000 per day per violation and would be effective upon enactment.

Background/rationale: Medicare HMOs decide each year whether to continue serving beneficiaries in selected counties or entire service areas. Plan decisions in 1998 led to just over

50,000 beneficiaries in 79 counties who were left with no other managed care option available. Preliminary reports suggest that more plans will drop out of Medicare this year. Beneficiaries who return to original fee-for-service Medicare may seek individual Medigap policies. Current law offers some protections, but these protections are not complete. The President's proposals would improve access to Medigap for beneficiaries whose plans withdraw from Medicare. The President's proposal for a prescription drug benefit available to all beneficiaries in both the traditional program and private plans will also help protect beneficiaries whose plans withdraw from Medicare.

4. Medicare Buy-In for Certain People Ages 55-65

Overview. Americans ages 55 to 65 are one of the most difficult populations to insure: they have less access to and a greater risk of losing employer-based health insurance; and they are twice as likely as people ages 45 to 55 to have health problems. Some lose their employer-based health insurance when their spouse (frequently the husband) becomes eligible for Medicare. Many lose their coverage because they lose their jobs due to company downsizing or plant closings. Still others lose insurance when their retiree health coverage is dropped unexpectedly. As a result, this is the fastest growing group of uninsured.

To address this problem, the President included in his FY1999 and 2000 budget submissions a targeted, paid-for proposal to give Americans nearing age 65 new options to obtain health care coverage. There are three parts to this proposal: The centerpiece of this proposal is a Medicare "buy-in", which allows eligible people to purchase Medicare coverage at a fair price. This is comparable to the Social Security option to allow people to begin to receive benefits at the age of 62, paid for by reducing the amount that they receive over the course of their retirement. It also assists displaced workers ages 55 and older by offering those who have involuntarily lost their jobs and their health care coverage a similar Medicare buy-in option. Thirdly, it providers Americans ages 55 and older whose companies reneged on their commitment to provide retiree health benefits a new health option by extending "COBRA" continuation coverage until age 65.

All three proposals are designed to be paid for by the people who benefit. People ages 62 to 64 who buy into Medicare will, over time, repay the amount that Medicare "loans" them when they are buying in. Displaced workers will pay a premium that takes into account participants' costs. And, the COBRA buy-in policy has no Federal budget impact whatsoever. The short-term Medicare "loan" to buy-in participants, plus the costs of the displaced workers' buy-in, will cost approximately $1.4 billion over 5 years. These costs will be financed by a series of offsets in the President's budget; as such, its costs are not included in the summary table for this plan. The initiative should help 300,000 to 400,000 people.

a. Medicare buy-in for people ages 62-64

Policy: People ages 62 through 64 (without access to employer-sponsored insurance) would be able to buy into Medicare early. They would pay for this coverage through a two-part premium "payment plan." First, participants would pay a base premium of about $300 per month — the average cost of insuring Americans in this age range. Second, participants would pay an additional monthly payment, estimated at $10 to $20, for each year that they buy into the Medicare program. This premium, to be paid once participants enter Medicare at age 65, would cover the extra costs of sicker participants. This two part "payment plan" enables these older Americans to buy into Medicare at a more affordable premium, while ensuring that the buy-in option is self-financing in the long run.

Background/rationale: People ages 62 to 64 are simultaneously the most likely to develop health problems and the least likely to have access to employer based health insurance. This forces them to turn to the individual insurance market, which can be expensive or denied altogether in most states. The Social Security program recognizes that some people in their early 60s may need access to benefits, and allows them to receive partial benefits. No such option is available in Medicare.

b. Medicare buy-in for displaced workers ages 55-62

Policy: The plan would also offer those who have involuntarily lost their jobs and their health care coverage a similar Medicare buy-in option. Individuals choosing this option will pay the entire premium at the time they receive the benefit without any Medicare "loan," in order to ensure that Medicare does not pay excessive up-front costs and participants do not have to make large payments after they turn 65 (although some Federal costs are expected due to adverse selection).

Background/rationale: This policy responds to the increased vulnerability of older Americans to work transitions and company layoffs. Such workers have a harder time finding new jobs: only 52 percent are reemployed compared to over 70 percent of younger workers. Nearly half of these unemployed, displaced workers who had health insurance remain uninsured.

c. Access to health insurance for retirees whose employers renege on coverage

Policy: This proposal allows retirees whose companies reneged on their commitment to provide retiree health benefits to buy into their former employers' health plan through age 65 by extending the availability of COBRA coverage to these families. This policy provides much needed access to affordable health care for these retirees and their dependents whose health care coverage is eliminated after they have retired. Retirees will pay a premium similar to that of other COBRA participants.

Background/rationale: In recent years, the number of companies offering retiree benefits has declined: in 1993, only about half of full-time workers in medium to large firms had access to

retiree health insurance, compared to 75 percent in 1985. Some companies have ended coverage only for future retirees, but others have dropped coverage for individuals who have already retired. It is often difficult to impossible for retirees to find affordable, alternative sources of health insurance.

III. STRENGTHENING MEDICARE'S FINANCING FOR THE 21st CENTURY

Overview. Medicare was created in 1965 with a social contract: workers would contribute to a trust fund to pay for basic health care for the elderly, with an understanding that when they turn 65, the next generation of workers will help pay for their care. This arrangement has worked successfully in the 20th century, with demonstrated improvements in health and security of the nation's elderly.

However, the 21st century brings new challenges. Like Social Security, Medicare enrollment will double between 1999 (39 million) and 2032 (78 million) as the baby boom generation retires. Not only will there be more elderly in the future, but the elderly will live up to 6 years longer on average by the middle of the next century. Compounding the demographic challenges are the unique factors that affect health spending -- changing disease patterns, technological advances, and a high value placed on health. As a result, health spending growth has historically exceeded that of general inflation. These trends are expected to continue into the next century. Private health spending growth per person is projected to be 7.3 percent between 1999 and 2007 -- more than twice as high as general inflation.

In addition to its demographic and financial challenges, Medicare approaches the next century without a basic tool needed to improve quality of care and the health of its beneficiaries: prescription drugs. Coverage of medications is absolutely essential to preventing, treating, and curing diseases. Its potential is even greater as advances in genetics and molecular biology translate into pharmaceutical therapies.

1. Extending the Life of the Medicare Trust Fund

Policy: This plan includes the President's commitment to dedicate part of the surplus to strengthen the Medicare trust fund and, indirectly, buy down the publicly held debt. The plan's contribution to solvency (in combination with Part A savings) would be $328.5 billion over 10 years, which has the effect of extending the life of the Trust Fund through 2027. For the amount that is being transferred from the surplus, the Treasury would buy down debt and then convey to the Medicare Trust Fund special purpose bonds (above and beyond the amount called for under current law). Legally binding procedures – a Medicare "Lock Box" -- would prevent the government from using these funds for any other purpose. These bonds would guarantee that Medicare will get the benefits that result from the fiscal improvement that debt reduction and lower net interest costs. By reducing debt held by the public, the framework would dramatically reduce the amount of net interest that the government would have to pay to service debt in the

future. This reduction in net interest costs will help free up the resources to allow the government to meet its existing Social Security and Medicare commitments.

Background/rationale: The President has an unparalleled record of strengthening and improving Medicare. When he took office, the Medicare Hospital Insurance (HI) Trust Fund was projected to be bankrupt this year -- 1999. Today, the Trust Fund is projected to be solvent through 2015 and Medicare spending growth rate per beneficiary is below that of private health spending.

However, Medicare's HI Trust Fund will become insolvent about 20 years earlier than Social Security and shortly after the baby boom generation starts to retire. Even with reforms that substantially slow cost growth, the revenues coming to the Medicare Trust Fund will not support the doubling of the number of beneficiaries that will occur by 2035. For these reasons, the President has proposed a framework for dedicating part of the surplus to Medicare.

As described earlier, sheer demographic changes alone will require that new financing be found for Medicare. Dedicating part of the surplus to the Medicare is both fair and forward-thinking. The unprecedented budget surplus was in part created by the actions and policies of the baby boom generation. Reductions in Medicare spending alone contributed to 40 percent of the overall spending declines resulting from the BBA. Additionally, the baby boom generation has spearheaded advances in technology and productivity that have contributed to increased economic growth and revenue. As such, dedicating part of the surplus to Medicare to prepare for their retirement is a fair approach to averting the fiscal crisis that would occur otherwise. It also prevents future generations from having their taxes raised to support their parents.

Dedicating part of the surplus for Medicare solvency not only assures the financial health of the Trust Fund through at least 2027 (in combination with the reform proposal's savings), but it will also reduce the need for future excessive cuts and radical restructuring that would be inevitable in the absence of these resources.

2. Responsibly Financing the New Prescription Drug Benefit

Policy: This plan would use $45.5 billion over 10 years in funds from the amount of the surplus dedicated to strengthening Medicare ($374 billion over 10 years, $794 billion over 15 years) to help finance the new prescription drug benefit. This amount would remain in general revenues since this is a source of financing for the SMI Trust Fund, from which this benefit would be run.

Background/rationale: The new drug benefit would cost about $118 billion over 10 years. It would be fully financed, mostly by savings from competition and efficiency. About 60 percent of the $118 billion Federal cost of the new Medicare prescription drug benefit would be offset through these savings.

A small portion of the cost of the drug benefit would be offset by $45.5 billion over 10 years from the surplus. There is a strong rationale for using part of the surplus dedicated to Medicare for the

prescription drug benefit. The 15 percent allocated from the surplus to Medicare is now higher than it was when the President made this commitment in January. The higher projections of the surplus in part result from lower Medicare spending under current law.

Policy experts advising the Congress (MedPAC, CBO, and the Medicare Trustees) have consistently stated their belief that much of the recent decline in Medicare spending beyond initial projections is due to our success in combating fraud and waste. Reinvesting the savings that can be reasonably attributed to our anti-fraud and waste activities into a new prescription drug benefit is completely consistent with the past actions of the Congress and the Administration utilizing such savings for programmatic improvements. This means that the plan could both achieve solvency through 2027 and help offset the costs of the new drug benefit. The amount going to the drug benefit is about one-eighth of the entire amount of the surplus committed to Medicare (and less than 2 percent of the entire surplus) and represents only about 40 percent of the 10-year total Federal benefit costs.